

Missouri Health Insurance Pool

Dear Applicant:

RE: Missouri Health Insurance Pool (MHIP)

Thank you for expressing interest in the MHIP program.

Please review the Eligibility Section of the brochure titled "Missouri Health Insurance Pool" to verify you qualify for the MHIP.

Enclosed is [descriptive information explaining the program](#), the [premium by gender and age](#) category rates for the four plans offered, and [forms](#) which you must complete and return (with proof of Missouri residency) should you choose to enroll in the MHIP. If you enroll, you will be sent more detailed plan description information, an Identification Card, and a Preferred Provider Directory. If you have specific questions that must be answered to determine whether or not you are interested, please call the Customer Service telephone number at the bottom of this letter.

As background information, the MHIP was created by the Missouri General Assembly to offer health insurance to Missouri residents that either: 1) have no current health insurance coverage or it is about to terminate; or 2) have current health coverage but is paying a premium that is [300% or more of the standard risk premium rate](#). The coverage is available but there is a cost to the enrollee to be covered under the MHIP. By statute, the MHIP must set premium rates at a level not to be below 150% but not to exceed 200% of the standard risk premium rate. As a result, the MHIP premiums often exceed what persons might be able to receive in the insurance marketplace. The intent of the MHIP is to provide coverage as a last resort to persons that cannot obtain insurance in the marketplace.

Please be advised that the MHIP plan requires application of a pre-existing condition exclusion to any medical condition for which the enrollee received medical advice, diagnosis or treatment during the six-month period prior to enrolling in the MHIP. However, **this exclusion is waived when** a person is involuntarily terminated from his/her existing health insurance coverage or if you qualify for the MHIP because the current premium you are paying equals or exceeds 300% of the standard risk rate. If you were involuntarily terminated by your previous health coverage, attach a copy of the termination letter with your application. If you qualify for the MHIP due to the 300% rule, attach a copy of your current carrier's or employer's premium statement.

If there you have any questions regarding this letter or the MHIP program, call BCBSMo's Customer Service number of 1-800-THE-MHIP (1-800-843-6447). If you have unresolved questions, you can call the MHIP's Executive Director, Cameron Ahrens, at (800) 821-2231.

Missouri Health Insurance Pool

**Managed health care coverage for Missourians
who are unable to obtain standard health coverage
because of high-risk health conditions**

Provided by the state of Missouri

In 1991, the Missouri General Assembly created the Missouri Health Insurance Pool (MHIP) to provide health care benefits for Missouri residents who are unable to obtain standard health insurance because of their high-risk health conditions.

The MHIP plan emphasizes managed health care. The plan administrators work with a select network of physicians, hospitals and other health care providers to help MHIP members obtain access to quality health care benefits. When MHIP members receive covered health care services from network providers, the plan provides a higher level of benefits and 100 percent coverage once the coinsurance maximum is reached.

In addition to the select provider network, MHIP includes specific managed care features, such as precertification and individual case management.

Important: The Missouri Health Insurance Pool's health care benefits are available only in the state of Missouri. If you receive health care services outside Missouri, these services will be covered by the MHIP program only if the administrator determines that they were emergency services or that the care is medically necessary but not available in Missouri and the cost of the care is similar to what the care would cost in Missouri.

Eligibility

The MHIP plan is available, on an individual basis, to residents of the state of Missouri who:

- are not eligible for or covered by health insurance, an insurance arrangement, continuation of coverage or conversion coverage, except for people whose premiums are 300 percent or more of standard insurance rates, as defined by the MHIP Board each calendar year.
- are not enrolled in both Parts A and B of Medicare.
- are not receiving health care benefits under Medicaid or Medical Assistance programs.
- are not inmates of a public institution or eligible for public programs.
- have not been denied insurance because of an alcohol or substance abuse conviction, or self-inflicted injury.
- were involuntarily terminated from their health insurance coverage for reasons other than non-payment of premiums or fraud.
- have not used \$1 million in benefits through the MHIP plan.
- have voluntarily terminated their MHIP plan membership and waited 12 months to reapply.

MHIP Plan Options

Important: The Missouri Health Insurance Pool benefits are available only in the state of Missouri. If you receive health care services outside Missouri, these services will be covered by the MHIP plan only if the administrator determines that they were emergency services or that the care is medically necessary but not available in Missouri and the cost of the care is similar to what the care would cost in Missouri.

Eligible individuals may choose among four plans for covered health care services:

	Plan I	Plan II	Plan III	Plan IV
Network providers or approved providers outside Missouri	\$500 deductible per calendar year	\$1,000 deductible per calendar year	\$2,500 deductible per calendar year	\$5,000 deductible per calendar year
Non-network providers in network area	\$1,000 deductible	\$2,000 deductible	\$5,000 deductible	\$10,000 deductible

Coinsurance: After the deductible is met, the plan will pay

80% for covered services received from network providers, for network or non-network emergency room care or ambulance services, or for medically necessary care that is unavailable in Missouri and approved in advance by the administrator, up to coinsurance maximum.

50% for covered services received from non-network providers within the network service area. The higher deductible applies, and there is no coinsurance maximum for these services. You must always pay 50% of the covered charges for care you receive outside Missouri if we determine it was urgent or emergency care (other than an emergency room or ambulance services). Other care outside Missouri is not covered.

Coinsurance Maximums: To help hold down your out-of-pocket expenses, the program includes a coinsurance maximum. **The maximum applies only to services received from network providers.** After the maximum is reached, the program covers 100% of eligible expenses for the rest of that calendar year. The coinsurance maximums are:

Plan I	Plan II	Plan III	Plan IV
\$2,500 per calendar year (in addition to Plan I deductible, above)	\$5,000 per calendar year (in addition to Plan II deductible, above)	\$5,000 per calendar year (in addition to Plan III deductible, above)	\$5,000 per calendar year (in addition to Plan IV deductible, above)

Benefit Maximum: The program benefit maximum under the MHIP plan is \$1,000,000 for all medical conditions, except for alcohol or substance abuse, which are limited to a lesser maximum. (See “Limitations and Exclusions.”)

Covered Services

Subject to the plan provisions, the MHIP plan will cover usual and customary charges for the following services, as prescribed by a licensed physician:

Inpatient Hospital Care (up to 180 days per calendar year)

- Semiprivate room and board and intensive care
- Operating, delivery and recovery rooms and supplies
- Prescribed drugs, injections and solutions
- Blood
- Miscellaneous services and supplies
- Maternity care
- Nursery charges
- Diagnostic services
- Therapy services

Outpatient Hospital Care

- Medical emergencies (covered at 80% in and out of network)
- Surgery
- Diagnostic services
- Therapy services

Physician Care

- Inpatient medical care
- Medical care provided in the office and home (excluding most routine care)
- Surgical services
- Anesthesia services
- Consultation services (inpatient only)
- Obstetrical care
- Diagnostic services
- Therapy services
- Certain oral surgery
- Routine childhood immunizations from network and non-network providers are covered at 100% for children through age 5.
- Flu shots
- Pap smears
- Colorectal and prostate cancer screenings and related tests

Other Providers of Care

- Home health agency care
- Ambulatory surgical center care
- Hospice care
- Suppliers of durable medical equipment, home respiratory therapy and home infusion therapy

Other Services and Supplies

- Prescription drugs
- Skilled nursing facility care
- Prosthetic appliances
- Ambulance services
- Oxygen
- Spiritual healing
- Patient education programs
- Human organ transplants
- One wig for hair loss due to chemotherapy or radiation therapy, up to \$125 in total benefits

Note: Certain limitations apply to treatment of mental illness and substance abuse. In addition, coverage is provided for spiritual healing, as defined by the MHIP plan. (See "Limitations and Exclusions.")

Managed Care Provisions

These managed care features are designed to help members get the most appropriate use of their benefits for health conditions.

- **Precertification and Recertification:** Precertification must be obtained from the Certification Center for any inpatient care, outpatient surgery and for home health care and skilled nursing facility care. If additional days are needed, recertification will be necessary. Network providers will assume responsibility for obtaining all certifications. However, if you choose to receive care from a non-network provider in the network service area, you will be responsible for obtaining precertification and recertification. In addition, your coinsurance will increase to 50 percent of covered charges, and these expenses will not apply toward the coinsurance maximum. If you do not obtain the required precertification or recertification, you will be responsible for the first 20 percent of eligible expenses, in addition to the deductible and coinsurance.
- **Concurrent Review, Discharge Planning and Retrospective Review:** Hospital confinements and costs are closely monitored both during and after a hospital stay. If it is determined that hospital care is no longer required, both the member and the physician will receive written notification. The member is encouraged to leave the hospital or to use alternative, less costly types of care if necessary. We will no longer cover hospital care after this notification. Additionally, certain inpatient claims are reviewed after payment to ensure that they were paid appropriately and to identify any unusual patterns in the use of health care services.
- **Individual Case Management:** With this provision, the Certification Center can work with you, your physician and the hospital to obtain voluntary mutual agreement on an alternative treatment setting, when appropriate, in cases of chronic, catastrophic or terminal illness. The goal is to maximize health care benefits.

Limitations and Exclusions

Preexisting Conditions: Health conditions for which medical advice, diagnosis, care or treatment was recommended or received within the six months preceding the effective date of coverage will not be covered for the first 12 months while the member is covered under the plan. However, the 12-month limitation will be waived if a similar waiting period has been satisfied under a prior health insurance coverage that was involuntarily terminated and application for coverage through MHIP is made within 60 days following the involuntary termination (except if the termination was due to fraud or nonpayment of premium). In addition, the 12-month limitation will be waived if a person's health insurance policy premium rate exceeds 300 percent of standard insurance rates, as defined by the MHIP Board each calendar year.

Mental Health Benefits: Benefits for inpatient mental health care are limited to 90 days per calendar year.

Alcohol and Substance Abuse Benefits: Benefits for alcohol and substance abuse care are limited to 26 visits of outpatient care; 21 days of inpatient or residential care, and six days of medical and social detoxification per calendar year. Benefits cover a lifetime limit of 10 episodes of care.

Spiritual Healing: Spiritual healing is covered. The program covers up to \$25 per session for up to 20 sessions per calendar year.

Services Not Covered

Following are some of the services that are not covered by the MHIP plan:

- Inpatient days in excess of 180 days per calendar year
- Charges in excess of allowed amount – the amount the administrator considers the appropriate charge
- Care that would otherwise be covered under a government program
- Care for any condition resulting from any act of war or while on active or reserve military duty
- Care provided outside the state of Missouri, unless deemed emergency care by the MHIP administrator.
- Inpatient hospital admissions primarily for diagnostic or therapy purposes, except when medically necessary
- Services provided after termination of the MHIP coverage
- Care that is not expressly specified in the MHIP Health Care Plan Document
- The difference between the hospital's most prevalent charge for a semiprivate room and a private room
- Charges for cosmetic or beautification services
- Foot care
- Routine or periodic physical examinations, except Pap smears, colorectal and prostate cancer screenings
- Dental treatment
- Eyeglasses or hearing aids or examinations for their prescription or fitting
- Convalescent, domiciliary or custodial care
- Intentionally self-inflicted injury, or injury or sickness occurring as a result of taking part in a felony
- Injury or sickness covered by workers' compensation, occupational disease law or similar laws, whether or not you claim those benefits
- Medical care, services and supplies to the extent that they are paid for or payable under Medicare or a state Medical Assistance program or automobile medical payment or liability insurance, whether provided on the basis of fault or no-fault, or other health insurance or insurance arrangement.
- Organ transplants that are considered experimental or investigational, such as intestine transplants. Transplants that are covered (with limits) include human donor cornea, skin, kidney, liver, heart, lung, heart-lung, and pancreas transplants.
- Care for or prescriptions drugs used for sexual dysfunction, including, but not limited to, male impotence medications (such as Viagra).
- Breast reduction (mammoplasty) unless to restore symmetry after a covered mastectomy
- Radial keratotomy and other refractive keratoplasty procedures, including LASIK procedures
- Orthoptic or pleoptic training (a type of eye exercise)
- Weight loss treatment or care for obesity, including drugs and surgery for morbid obesity

**For more information call ...
1-800-THE-MHIP
(1-800-843-6447)**

Caution: We recommend careful consideration of the following points:

- Even though your current health care plan may have some coverage restrictions, its price to benefits comparison may still represent a better health care coverage value.
- The law creating MHIP provides that the premium rates charged by MHIP may be directly related to the premium rates charged by the five health insurers with the largest number of people covered in each type of plan. Therefore, as the average premium rates of these health insurers increase, so may the MHIP premium rates increase.
- No benefits are payable during the first 12 months for care related to any health condition for which medical advice, diagnosis, care or treatment was recommended or received within the six months preceding the effective date of MHIP coverage.
- MHIP coverage can be continued for each covered person only while he/she remains a Missouri resident.
- This brochure contains only a summary of benefits and exclusions of the Missouri Health Insurance Pool (MHIP) plan and is not part of the certificate. Complete details of benefits and exclusions and the terms under which they are provided are contained in the MHIP certificate, issued to the member when his/her coverage is approved. A copy is available upon request.
- Referring agents are not authorized to interpret, amend or alter the terms of the MHIP insurance policy, nor are referring agents authorized to bind MHIP in any way.

How to Apply

Complete the enclosed MHIP Application for Coverage (form No. AMK-834D), and submit it with one or more of the following documents:

- A letter or form documenting the underwriting action taken by the Underwriting Department or an authorized representative of a Missouri licensed health insurer or health plan. The underwriting action must indicate that coverage was refused, or offered at a premium of at least three times the standard premium, or offered with restrictive riders that limit benefits for specific conditions.
- A notice indicating that you have been involuntarily terminated from your health care coverage within the past 60 days and are unable to obtain continuation of coverage. Include the date of this event.
- If you are over age 65, documentation indicating that you are not eligible for Medicare.

You may also apply through any Missouri licensed agent or broker. They can help you with enrollment questions and with comparisons of plans and premiums.

Note: *Please do not submit any payment with your application. If you are eligible for coverage, you will receive a billing statement after your application has been approved.*

Notification of Acceptance or Denial of Coverage: If your MHIP Application for Coverage meets all plan requirements, the MHIP administrator will notify you within 30 days of your acceptance or denial. A benefit booklet and identification card will be issued to each applicant who is accepted. With certain exceptions, coverage becomes effective on the first of the month following MHIP approval of your application and any additional required information.

Effective dates and premium payments:

In most cases, eligible applicants who are accepted for MHIP membership will have coverage effective on the first day of the month they are eligible, unless their prior coverage terminated sooner and they desire uninterrupted, continuous coverage.

For more information, please contact:

Missouri Health Insurance Pool
c/o Underwriting Department
P.O. Box 419169
Kansas City, MO 64179-0147

Administered by Blue Cross and Blue Shield of Missouri and Blue Cross and Blue Shield of Kansas City,
independent licensees of the Blue Cross and Blue Shield Association.

Missouri Health Insurance Pool

Application and Health Statement

Important: Only certain individuals are eligible for coverage through the Missouri Health Insurance Pool (MHIP). For complete details, please read "Eligibility" in the Missouri Health Insurance Pool brochure.

Completed Application and Health Statement form should be submitted to:

**Missouri Health Insurance Pool
c/o Claims Administrator
1831 Chestnut Street
St. Louis, MO 63103-2275**

Application

Please print. If you make any changes while completing this form (for example, if you cross out something you wrote), be sure to initial and date those changes.

1. Applicant's Information

A. Name: Last First Middle			<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth (mo / day / yr)
Address: Street City State Zip Code			County	
Telephone number Area Code ()	Alternate phone number Area Code ()	Height	Weight Now 1 yr. Ago	Social Security number
B. Person whom MHIP may contact in case of emergency: Name: Last First Middle				Relationship to applicant
Address: Street City State Zip Code				Telephone number Area Code ()

2. MHIP Deductible Selection (check only one): These annual deductible amounts will double for non-network care. (See brochure.)
☐ Plan I \$ 500 ☐ Plan II \$1,000
☐ Plan III \$2,500 ☐ Plan IV \$5,000

3. Eligibility for Other Health Care Coverage: Are you eligible for (but not enrolled in) HIPAA* coverage or any other health care coverage? ☐ Yes ☐ No If YES, would your premium under that coverage be more than 300% of standard insurance rates, as defined by the MHIP Board each calendar year? (See brochure.) ☐ Yes ☐ No

*Health Insurance Portability and Accountability Act of 1996.

4. Current Health Care Coverage Information

A. Are you currently enrolled in other health care coverage, including Medicare, Medicaid or coverage provided by your employer or your spouse's employer (including continuation coverage and conversion coverage)? ☐ Yes ☐ No If YES, please provide the termination date of existing coverage: mo. ____ / day ____ / yr. _____. (MHIP coverage cannot be issued if other coverage is in effect.) Also, if YES, please complete B, C and D, below. (Attach an extra sheet if necessary.)

B. Name of Primary Person Covered	Name of Insurance Company	Policy Number	Is this coverage provided by your employer?	Is this coverage provided by your spouse's employer?
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Has any insurance company required you to satisfy a waiting period before providing benefits for preexisting health conditions? ☐ Yes ☐ No If YES, please complete all information below. (Attach an extra sheet if necessary.)

Name of Insurance Company	Length of waiting period	Was waiting period satisfied?	If YES, provide date waiting period ended
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	

D. Please provide premium information. (Attach an extra sheet if necessary.) Please also attach a copy of each insurance company's most recent billing statement.

Name of Insurance Company	Name of primary person covered	Most recent monthly premium	Do you intend to cancel because of premium amount?
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

5. Denial(s) of Coverage and/or Exclusions of Health Conditions

- A. Have you been involuntarily terminated from health coverage within the past 60 days? ☐ Yes ☐ No If YES, what was the reason? _____
- B. Have you **ever** been offered health coverage with restrictive riders that would limit coverage for specific conditions? ☐ Yes ☐ No
- C. Have you **ever** been denied coverage because of substance abuse, including alcoholism, and/or because of self-inflicted injury? ☐ Yes ☐ No
- D. In the past three years, have you been charged and convicted of an alcohol or substance abuse-related crime? ☐ Yes ☐ No

Health Statement Section

All questions must be answered before we can process your application. Your health status will not disqualify you for MHIP, but certain limitations on benefits for preexisting conditions may apply.

During the past six months, have you ever had or been advised of, positively diagnosed with, or treated for any of the following conditions?

Each item must be checked either "Yes" or "No." Also, please circle all conditions that apply; for example: **Arthritis.**

1. Anemia, other blood disease or disorder ☐ Yes ☐ No
2. Arthritis, lupus, gout or any inflammation, recurrent pain or diminished range of motion in the joints, including knees or hips (please indicate the involved joint – see the following page) ☐ Yes ☐ No
3. Back, neck or spinal column disorders, including back adjustments, recurrent back pain or immobility ☐ Yes ☐ No
4. Bladder infections, kidney infections, kidney stones, or any other bladder, urinary or kidney disorder ☐ Yes ☐ No
5. Breast disorder, fibrocystic disease, breast implant or reduction ☐ Yes ☐ No
6. Cancer, cysts, tumors, polyps or other growths ☐ Yes ☐ No
7. Congenital disease or birth defect ☐ Yes ☐ No
8. Diabetes, goiter or thyroid disorder or disorder of the glands ☐ Yes ☐ No
9. Eating disorder, such as anorexia or bulimia ☐ Yes ☐ No
10. Emphysema, bronchitis or any chest, lung or respiratory problem or disorder ☐ Yes ☐ No
11. Epilepsy, seizures, migraine or recurrent headaches ☐ Yes ☐ No
12. Fractures, dislocations, polio, loss of limb(s), bone disorders. (On the following page, please indicate the involved limb[s] [left or right, arm or leg] and if screws, pins or plates are now in place.) ☐ Yes ☐ No
13. Gallstones, gallbladder disorder, hernia (except hiatal) ☐ Yes ☐ No
14. Sexually-transmitted diseases, such as genital herpes, syphilis, gonorrhea, chlamydia or venereal warts ☐ Yes ☐ No
15. Heart murmur, irregular heartbeat, rheumatic fever, chest pain, heart valve problem, heart attack or any other heart condition ☐ Yes ☐ No
16. Hepatitis, cirrhosis or any other liver disorder ☐ Yes ☐ No
17. Disorder of the male or female reproductive organs, including enlarged prostate, prostatitis, menstrual irregularity or disorder, fibroid uterus, abnormal pap smear or ovarian cyst ☐ Yes ☐ No
18. Muscular or neurological disorder, such as muscular dystrophy, multiple sclerosis, cerebral palsy or Parkinson's .. ☐ Yes ☐ No
19. Nervous, mental or emotional condition; attempted suicide, depression or mental retardation ☐ Yes ☐ No
20. Paralysis, stroke, TIA or high blood pressure ☐ Yes ☐ No
21. Ulcers, colitis, hemorrhoids, ulcerative colitis, Crohn's, hiatal hernia or any other stomach, intestine, bowel or rectal disorder ☐ Yes ☐ No
22. Varicose veins, clots, poor circulation or any other vein or artery disorder ☐ Yes ☐ No

During the past six months, have you:

23. Had an operation or been hospitalized? ☐ Yes ☐ No
24. Been diagnosed with, or treated for, Human Immunodeficiency Virus (HIV) infection? ☐ Yes ☐ No
25. Been treated or counseled for alcoholism, the use of alcohol, drug abuse or the use of drugs? ☐ Yes ☐ No
27. Had any other condition, disorder, ailment or injury not listed above for which you have had or plan to seek advice, diagnosis or treatment? ☐ Yes ☐ No
28. Consulted a doctor, chiropractor, therapist or other health care provider? ☐ Yes ☐ No

Health Statement – All questions must be answered before we can process your application.

29. If you answered YES to any of the questions 1-28, complete this section. Give complete details, including the number of each item that you answered YES. Attach additional sheet if necessary.

Item No.	Dates of Illness or Conditions/ Symptoms	Diagnosis, Treatment, Medication, Reason for Visit	Is further treatment needed?	Were you hospitalized?	Name and Address of Doctor and/or Hospital
	From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
	To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
	From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
	To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
	From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
	To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
	From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
	To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
	From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
	To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address
	From		<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	Name
	To		<input type="checkbox"/> No	<input type="checkbox"/> No	Address

30. Have you taken prescribed medications within the last year? ☐ Yes ☐ No If YES, please complete:

Medicine	Dosage	Reason	Name and address of prescribing doctor
Medicine	Dosage	Reason	Name and address of prescribing doctor

31. Your current primary physician:

Name: _____ Last First Middle			Specialty:
Address _____ Office / Suite # Street			
City State Zip Code			Telephone number: Area Code ()

32. Has future surgery, diagnostic testing or medical treatment been recommended or discussed for you? ☐ Yes ☐ No
If YES, please complete:

Date	Diagnosis	Type of operation or treatment

(Note to parents/legal guardians: If your child is under age 18 and is applying for his/her own membership, please sign as indicated below to show your consent and indicate your relationship to the applicant.)

X _____ X _____ X _____
(Applicant's Signature if Age 18 or Older / Parent's or Legal Guardian's Signature if Applicant is under Age 18) (Relationship to Applicant) (Date)

Office Use Only	Group #	I.D. #	Membership Type	Package #	Effective Date

Missouri Health Insurance Pool Affirmation Form

Please read carefully and sign below.

Name of Applicant: _____
(please print)

I hereby apply for Missouri Health Insurance Pool (MHIP) coverage, as offered by the state of Missouri. I understand and agree to everything listed below:

- **I certify that all the information I provided on my application is true and complete. I understand that my MHIP membership can be canceled retroactively to the effective date of coverage if it is later found that I provided any false or incomplete information on this application. Then I must repay any benefits that I was not entitled to receive.**
- I will pay monthly the dues billed by MHIP for the benefits that I requested.
- If my dues are not paid within 10 days after the due date, my MHIP coverage will end as of the date payment was due.
- I authorize and direct any physician, dentist, hospital, clinic, medically related facility or other provider of health care services or supplies to release to the Administrator all necessary information about my care for the purposes of underwriting my coverage and providing benefits. In addition, I authorize the Administrator to release information about my medical care in order to comply with state, federal or national accrediting body standards or for research purposes or for the purpose of measuring, assuring and/or improving the quality of my medical care.
- **I understand that MHIP program benefits may not be payable during the 12 months after coverage is effective, for any health conditions, or signs of symptoms thereof, that were known, diagnosed or treated during the six months preceding the coverage effective date. I understand that MHIP will notify me upon approval of my application as to whether this 12-month waiting period will apply to my MHIP benefits for such conditions.**
- I have attached copies of two written proofs of Missouri residency (e.g.; electric bill, gas bill, driver's license).
- I have enclosed an original document issued to me within the past 60 days by a duly licensed Missouri health insurance company, terminating my coverage for reasons other than fraud or nonpayment of premium; or I have enclosed an original billing statement from a duly licensed Missouri health insurance company.
- I agree that MHIP may use any reasonable means to investigate and verify the information I have provided in this application.
- I understand that this is an application only. I will be notified in writing if I am accepted into the MHIP program. **I should not cancel any existing health care coverage before I receive this notice.**
- I understand that I must initial and date any changes I make while I am completing my MHIP application.
- **I understand that my coinsurance amount will increase to 50% of eligible expenses if I receive covered care from non-network providers, urgent care outside Missouri or emergency services outside Missouri from a provider other than a hospital emergency room or ambulance provider. These expenses will not apply toward the annual Coinsurance Maximum.* I will also be responsible for obtaining Precertification and Recertification from the Certification Center for any inpatient care, outpatient surgery, home health care or skilled nursing facility care.**
**Exception: I understand that if I receive covered services from a health care provider outside Missouri, my coinsurance amount will be the same as if I had received the services from a network provider, as long as the care has been authorized in advance by the Administrator and the Administrator has determined that the care is not available in Missouri.*
- **I will let MHIP know if and when I am no longer eligible for MHIP coverage because of a change in residence, or if I become an inmate of a public institution or because of enrollment in Medicare Parts A and B or eligibility for Medicaid or other health care coverage.**

(Note to parents/legal guardians: If your child is under age 18 and is applying for his/her own membership, please sign as indicated below to show your consent and indicate your relationship to the applicant.)

X _____ X _____ X _____
(Applicant's Signature if Age 18 or Older/
Parent's or Legal Guardian's Signature
if Applicant is under Age 18) (Date) (Relationship to Applicant)

X _____ X _____
(Signature of Witness) (Date)

Applicant: After signing, please keep the yellow copy for your records.

MISSOURI HEALTH INSURANCE POOL 2002 Monthly Premiums

Monthly 2002 MHIP Premiums effective 4/1/02

Age Group	PLAN I Male	PLAN I Female	PLAN II Male	PLAN II Female
0-17	\$ 166	\$ 166	\$ 130	\$ 130
18-29	\$ 222	\$ 394	\$ 172	\$ 310
30-39	\$ 282	\$ 457	\$ 221	\$ 355
40-44	\$ 373	\$ 492	\$ 296	\$ 397
45-49	\$ 462	\$ 546	\$ 369	\$ 441
50-54	\$ 583	\$ 616	\$ 467	\$ 508
55-59	\$ 725	\$ 695	\$ 586	\$ 576
60-64	\$ 919	\$ 781	\$ 740	\$ 644

Monthly 2002 MHIP Premiums effective 4/1/02

Age Group	PLAN III Male	PLAN III Female	PLAN IV Male	PLAN IV Female
0-17	\$ 96	\$ 96	\$ 77	\$ 77
18-29	\$ 128	\$ 243	\$ 103	\$ 187
30-39	\$ 166	\$ 273	\$ 137	\$ 228
40-44	\$ 226	\$ 310	\$ 186	\$ 259
45-49	\$ 284	\$ 340	\$ 233	\$ 285
50-54	\$ 357	\$ 401	\$ 294	\$ 327
55-59	\$ 450	\$ 453	\$ 368	\$ 373
60-64	\$ 560	\$ 497	\$ 467	\$ 410

NOTE: The Missouri statute creating the MHIP specifically states that a person eligible for Medicare Parts A & B is not eligible for coverage through the MHIP. Since there are a few rare circumstances where a Missouri resident is 65 or more years and not eligible for Medicare, we do have premium rates for persons over age 65 years. To be covered through the MHIP, such persons need special approval. If you need these premium rates, you must contact the MHIP Executive Director at 1-800-821-2231.

MISSOURI HEALTH INSURANCE POOL 2002 "300% of Standard" Premiums

Monthly "300% of Standard" Premiums effective 4/1/02

Age Group	PLAN I	PLAN I	PLAN II	PLAN II
	Male	Female	Male	Female
0-17	\$ 285	\$ 285	\$ 222	\$ 222
18-29	\$ 381	\$ 675	\$ 294	\$ 531
30-39	\$ 483	\$ 783	\$ 378	\$ 609
40-44	\$ 639	\$ 843	\$ 507	\$ 681
45-49	\$ 792	\$ 936	\$ 633	\$ 756
50-54	\$ 999	\$ 1,056	\$ 801	\$ 870
55-59	\$ 1,242	\$ 1,191	\$ 1,005	\$ 987
60-64	\$ 1,575	\$ 1,338	\$ 1,269	\$ 1,104

Monthly "300% of Standard" Premiums effective 4/1/02

Age Group	PLAN III	PLAN III	PLAN IV	PLAN IV
	Male	Female	Male	Female
0-17	\$ 165	\$ 165	\$ 132	\$ 132
18-29	\$ 219	\$ 417	\$ 177	\$ 321
30-39	\$ 285	\$ 468	\$ 234	\$ 390
40-44	\$ 387	\$ 531	\$ 318	\$ 444
45-49	\$ 486	\$ 582	\$ 399	\$ 489
50-54	\$ 612	\$ 687	\$ 504	\$ 561
55-59	\$ 771	\$ 777	\$ 630	\$ 639
60-64	\$ 960	\$ 852	\$ 801	\$ 702

NOTE: The Missouri statute creating the MHIP specifically states that a person eligible for Medicare Parts A & B is not eligible for coverage through the MHIP. Since there are a few rare circumstances where a Missouri resident is 65 or more years and not eligible for Medicare, we do have premium rates for persons over age 65 years. To be covered through the MHIP, such persons need special approval. If you need these premium rates, you must contact the MHIP Executive Director at 1-800-821-2231.